



Facility Name & ID Number COUNTRYSIDE CARE CENTRE

# 0040931 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	131	Skilled (SNF)	131	47,815	1
2		Skilled Pediatric (SNF/PED)			2
3	76	Intermediate (ICF)	76	27,740	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	207	TOTALS	207	75,555	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	10,130	1,402	9,478	21,010	8
9	SNF/PED					9
10	ICF	44,111	6,104		50,215	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	54,241	7,506	9,478	71,225	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.27%

D. How many bed-hold days during this year were paid by the Department? 42 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

I. On what date did you start providing long term care at this location?  
Date started 07/01/94

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 07/01/94 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 130 and days of care provided 6,067

Medicare Intermediary WPS (WISCONSIN PHYSICIAN SERVICE)

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **COUNTRYSIDE CARE CENTRE** # **0040931** Report Period Beginning: **01/01/2007** Ending: **12/31/2007**

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	352,714	27,967	23,679	404,360		404,360	(1,399)	402,961		1
2	Food Purchase		303,636		303,636		303,636	(3,490)	300,146		2
3	Housekeeping	293,577	52,844		346,421		346,421	(1,418)	345,003		3
4	Laundry	43,021	28,515	7,712	79,248		79,248	(3,437)	75,811		4
5	Heat and Other Utilities			255,511	255,511		255,511		255,511		5
6	Maintenance	48,765	63,955	38,072	150,792		150,792	1,400	152,192		6
7	Other (specify):*			49,785	49,785		49,785		49,785		7
8	<b>TOTAL General Services</b>	738,077	476,917	374,759	1,589,753		1,589,753	(8,344)	1,581,409		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			15,000	15,000		15,000		15,000		9
10	Nursing and Medical Records	4,483,124	346,273	129,557	4,958,954		4,958,954	(71,617)	4,887,337		10
10a	Therapy	56,331		735	57,066		57,066		57,066		10a
11	Activities	126,521	8,336	17,131	151,988		151,988	(1,345)	150,643		11
12	Social Services	96,569		10,202	106,771		106,771		106,771		12
13	CNA Training			519	519		519		519		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	4,762,545	354,609	173,144	5,290,298		5,290,298	(72,962)	5,217,336		16
	<b>C. General Administration</b>										
17	Administrative	212,560		1,020,214	1,232,774		1,232,774	(1,024,455)	208,319		17
18	Directors Fees										18
19	Professional Services			455,666	455,666		455,666	(263,384)	192,282		19
20	Dues, Fees, Subscriptions & Promotions			119,815	119,815		119,815	(86,939)	32,876		20
21	Clerical & General Office Expenses	199,536	44,498	48,142	292,176		292,176	227,260	519,436		21
22	Employee Benefits & Payroll Taxes			1,031,715	1,031,715		1,031,715		1,031,715		22
23	Inservice Training & Education			9,808	9,808		9,808		9,808		23
24	Travel and Seminar			1,141	1,141		1,141	14,627	15,768		24
25	Other Admin. Staff Transportation			5,762	5,762		5,762		5,762		25
26	Insurance-Prop.Liab.Malpractice			161,232	161,232		161,232	8,787	170,019		26
27	Other (specify):*			269,765	269,765		269,765	(269,765)			27
28	<b>TOTAL General Administration</b>	412,096	44,498	3,123,260	3,579,854		3,579,854	(1,393,869)	2,185,985		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,912,718	876,024	3,671,163	10,459,905		10,459,905	(1,475,175)	8,984,730		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	19,588
	REPAIRS & MAINTENANCE	4,091
		0
		23,679
3	<b>HOUSEKEEPING</b>	
		0
		0
		0
4	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	7,712
		0
		7,712
5	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	70,756
	ELECTRICITY	92,835
	WATER	91,920
	CABLE TV - LOBBY	0
		0
		255,511
6	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	16,554
	PAINTING & DECORATING	1,314
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	9,128
	ELEVATOR MAINTENANCE & REPAIR	5,988
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	3,342
	FIRE SERVICE	1,746
		0
		0
		0
		0
		38,072
7	<b>OTHER</b>	
	SCAVENGER	46,499
	SECURITY SERVICE	3,286
		0
		0
		49,785
9	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	15,000
		15,000

LINE	SCHED REF	TOTAL
10	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B ___-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,504
	PHARMACY CONSULTANT XVIII B 39-2	2,400
	UTILIZATION REVIEW FEES XVIII B 46-2	6,000
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	119,653
		0
		0
		129,557
10a	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	735
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		735
11	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	16,066
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	1,065
		0
		17,131
12	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	9,000
	SOCIAL WORKER XVIII B 45-2	1,202
		0
		10,202
13	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	519
		519

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
<b>14</b>	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	0
<b>17</b>	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	1,020,214
<b>18</b>	<b>DIRECTORS FEES</b>	
	DIRECTORS FEES	0
<b>19</b>	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	32,279
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	423,387
		0
		455,666
<b>20</b>	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	66,919
	EMPLOYEE WANT ADS XIX F	10,686
	CONTRIBUTIONS VI 20 XIX F	298
	DUES & SUBSCRIPTIONS XIX F	12,534
	LICENSES & PERMITS XIX F	3,426
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	20,169
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	900
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,803
	PATIENT BACKGROUND CHECKS XIX F	3,080
		119,815
<b>21</b>	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	6,997
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	3,573
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	34,302
	MESSENGER SERVICE	3,270
		0
		48,142

LINE	SCHED REF	TOTAL
<b>22</b>	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	444,740
	UNEMPLOYMENT COMPENSATION XIX D	85,757
	WORKERS COMPENSATION INSURANC XIX D	122,656
	HOSPITALIZATION INSURANCE XIX D	359,066
	EMPLOYEE BENEFITS - OTHER XIX D	8,064
	EMPLOYEE PHYSICAL EXAMS XIX D	700
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	10,732
	CHICAGO HEAD TAX XIX D	0
		0
		1,031,715
<b>23</b>	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	9,808
		9,808
<b>24</b>	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	1,141
		1,141
<b>25</b>	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	5,762
		5,762
<b>26</b>	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	161,232
		161,232
<b>27</b>	<b>OTHER</b>	
	BAD DEBTS VI 24	269,765
		269,765

GRAND TOTAL COLUMN 3 OTHER

3,671,163

**COUNTRYSIDE CARE CENTRE  
SCHEDULES  
12/31/2007**

**EMPLOYEE MEAL RECLASSIFICATION  
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22**

TOTAL FOOD PURCHASE	303,636
LESS SALES TAX	<u>(3,490)</u>
NET FOOD	300,146

TOTAL PATIENT CENSUS	71,225
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	213,675

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	213,675
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	213,675

NET FOOD	300,146
DIVIDE TOTAL MEALS/YEAR	<u>213,675</u>

COST PER MEAL	1.40
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>0</b>

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Facility Name &amp; ID Number

COUNTRYSIDE CARE CENTRE

#0040931

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			113,434	113,434		113,434	217,684	331,118			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			236,233	236,233		236,233	261,932	498,165			32
33	Real Estate Taxes			154,691	154,691		154,691		154,691			33
34	Rent-Facility & Grounds			762,850	762,850		762,850	(709,181)	53,669			34
35	Rent-Equipment & Vehicles			33,448	33,448		33,448	11,203	44,651			35
36	Other (specify):* MTG INSURANCE							23,246	23,246			36
37	<b>TOTAL Ownership</b>			1,300,656	1,300,656		1,300,656	(195,116)	1,105,540			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		435,949	1,308,184	1,744,133		1,744,133		1,744,133			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			113,333	113,333		113,333		113,333			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		435,949	1,421,517	1,857,466		1,857,466		1,857,466			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,912,718	1,311,973	6,393,336	13,618,027		13,618,027	(1,670,291)	11,947,736			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.**

**In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(5,294)	30		9
10	Interest and Other Investment Income	(14,536)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,490)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(3,573)	21		18
19	Entertainment		20		19
20	Contributions	(1,198)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(36,369)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(269,765)	27		24
25	Fund Raising, Advertising and Promotional	(66,919)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(20,169)	20		28
29	Other-Attach Schedule	(12,439)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (433,752)</b>		<b>\$</b>	<b>30</b>

<b>BHF USE ONLY</b>					
48	49	50	51	52	

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,236,539)	PG 6-6D	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (1,236,539)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (1,670,291)</b>		<b>37</b>

**\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)**

		1	2	3	4
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>	<b>47</b>

COUNTRYSIDE CARE CENTRE

ID# 0040931

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 1,998	6	1
2	VACATION ACCRUAL	(1,399)	1	2
3	VACATION ACCRUAL	(1,418)	3	3
4	VACATION ACCRUAL	(3,437)	4	4
5	VACATION ACCRUAL	(598)	6	5
6	VACATION ACCRUAL	(1,197)	10	6
7	VACATION ACCRUAL	(1,345)	11	7
8	VACATION ACCRUAL	(4,241)	17	8
9	VACATION ACCRUAL	5,472	21	9
10	MEDICARE A CONSULTANT	(2,000)	19	10
11	MEDICARE A BILLING	(209)	19	11
12	MARKETING CONSULTANT	(4,065)	19	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(12,439)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number COUNTRYSIDE CARE CENTRE# 0040931

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(1,399)	0	0	0	0	0	0	0	0	0	0	(1,399)	1
2	Food Purchase	(3,490)	0	0	0	0	0	0	0	0	0	0	(3,490)	2
3	Housekeeping	(1,418)	0	0	0	0	0	0	0	0	0	0	(1,418)	3
4	Laundry	(3,437)	0	0	0	0	0	0	0	0	0	0	(3,437)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	1,400	0	0	0	0	0	0	0	0	0	0	1,400	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(8,344)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(8,344)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,197)	0	0	(70,420)	0	0	0	0	0	0	0	(71,617)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,345)	0	0	0	0	0	0	0	0	0	0	(1,345)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(2,542)</b>	<b>0</b>	<b>0</b>	<b>(70,420)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(72,962)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(4,241)	0	(765,160)	0	0	(255,054)	0	0	0	0	0	(1,024,455)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(42,643)	9,580	61,067	1,040	(292,428)	0	0	0	0	0	0	(263,384)	19
20	Fees, Subscriptions & Promotions	(88,286)	0	563	154	630	0	0	0	0	0	0	(86,939)	20
21	Clerical & General Office Expenses	1,899	0	12,741	1,743	210,877	0	0	0	0	0	0	227,260	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	5,810	4,173	4,644	0	0	0	0	0	0	14,627	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,374	2,753	3,660	0	0	0	0	0	0	8,787	26
27	Other (specify):*	(269,765)	0	0	0	0	0	0	0	0	0	0	(269,765)	27
28	<b>TOTAL General Administration</b>	<b>(403,036)</b>	<b>9,580</b>	<b>(682,605)</b>	<b>9,863</b>	<b>(72,617)</b>	<b>(255,054)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,393,869)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(413,922)</b>	<b>9,580</b>	<b>(682,605)</b>	<b>(60,557)</b>	<b>(72,617)</b>	<b>(255,054)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,475,175)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number COUNTRYSIDE CARE CENTRE# 0040931

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(5,294)	216,911	589	265	5,213	0	0	0	0	0	0	217,684	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(14,536)	276,468	0	0	0	0	0	0	0	0	0	261,932	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(762,850)	0	2,124	51,545	0	0	0	0	0	0	(709,181)	34
35	Rent-Equipment & Vehicles	0	0	3,787	4,289	3,127	0	0	0	0	0	0	11,203	35
36	Other (specify):*	0	23,246	0	0	0	0	0	0	0	0	0	23,246	36
37	<b>TOTAL Ownership</b>	<b>(19,830)</b>	<b>(246,225)</b>	<b>4,376</b>	<b>6,678</b>	<b>59,885</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(195,116)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(433,752)</b>	<b>(236,645)</b>	<b>(678,229)</b>	<b>(53,879)</b>	<b>(12,732)</b>	<b>(255,054)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,670,291)</b>	<b>45</b>

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF OWNERS		SEE ATTACHED LIST OF RELATED NURSING HOMES		COUNTRYSIDE HEALTH CARE CENTRE		
					MORTON GROVE, IL	REAL ESTATE
				SEE ATTACHED LIST OF OTHER RELATED ENTITIES		

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 RENT	\$ 762,850	COUNTRYSIDE HEALTH CARE CENTRE		\$	(762,850)	1
2	V	36 MORTGAGE INSURANCE		"		23,246	23,246	2
3	V	30 DEPRECIATION-BLDG/IMP		"		216,455	216,455	3
4	V	30 DEPRECIATION - EQPT/FURN		"		456	456	4
5	V	32 AMORTIZATION - MTG COST		"		1,283	1,283	5
6	V	32 INTEREST - MORTGAGE		"		251,181	251,181	6
7	V	32 INTEREST - OTHER		"		24,004	24,004	7
8	V	19 ACCOUNTING FEES		"		9,364	9,364	8
9	V	19 DATA PROCESSING		"		216	216	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 762,850			\$ 526,205	\$ * (236,645)	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

**VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 PROFESSIONAL FEES	\$	WITTINGHAM MANAGEMENT ASSOCIATES		\$ 61,067	\$ 61,067
16	V	20 DUES & SUBSCRIPTIONS		"		563	563
17	V	21 CLERICAL		"		12,741	12,741
18	V	24 TRAVEL		"		5,810	5,810
19	V	26 INSURANCE		"		2,374	2,374
20	V	35 RENT - EQPT & VEHICLE		"		3,787	3,787
21	V	17 ADMINISTRATIVE	765,160	"			(765,160)
22	V	30 DEPRECIATION		"		589	589
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 765,160			\$ 86,931	\$ * (678,229)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

**VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	10 NURSING	\$ 119,393	CARLYLE NURSING ASSOCIATES, LLC		\$ 48,973	\$ (70,420)
16	V	19 PROFESSIONAL FEES		"		1,040	1,040
17	V	20 DUES & SUBSCRIPTIONS		"		154	154
18	V	21 CLERICAL		"		1,743	1,743
19	V	24 TRAVEL		"		4,173	4,173
20	V	26 INSURANCE		"		2,753	2,753
21	V	30 DEPRECIATION		"		265	265
22	V	34 RENT		"		2,124	2,124
23	V	35 RENT - EQPT & VEHICLE		"		4,289	4,289
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 119,393			\$ 65,514	\$ * (53,879)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 PROFESSIONAL FEES	\$ 297,867	THE KENSINGTON GROUP, LLC		\$ 5,439	\$ (292,428)
16	V	20 DUES & SUBSCRIPTIONS		"		630	630
17	V	21 CLERICAL		"		210,877	210,877
18	V	24 TRAVEL		"		4,644	4,644
19	V	26 INSURANCE		"		3,660	3,660
20	V	30 DEPRECIATION		"		5,213	5,213
21	V	34 RENT		"		51,545	51,545
22	V	35 RENT - EQPT & VEHICLES		"		3,127	3,127
23	V			"			
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 297,867			\$ 285,135	\$ * (12,732)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 ADMINISTRATIVE	\$ 255,054	CHESTERFIELD		\$	\$ (255,054)
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 255,054			\$ 0	\$ * (255,054)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE # 0040931 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

# 0040931 Report Period Beginning: 01/01/2007

Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization WITTINGHAM MANAGEMENT ASSOC. LLC  
 Street Address 8140 RIVER DRIVE  
 City / State / Zip Code MORTON GROVE, IL 60053  
 Phone Number ( 847) 583-0100  
 Fax Number ( 847) 583-8873

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	368,840	7	\$ 316,248	\$ 71,225	\$ 61,067	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	368,840	7	2,914	71,225	563	2
3	21	CLERICAL	PATIENT DAYS	368,840	7	65,982	71,225	12,741	3
4	24	TRAVEL	PATIENT DAYS	368,840	7	30,090	71,225	5,810	4
5	26	INSURANCE	PATIENT DAYS	368,840	7	12,294	71,225	2,374	5
6	35	RENT - EQPT & VEH	PATIENT DAYS	368,840	7	19,611	71,225	3,787	6
7									7
8	30	DEPRECIATION	PATIENT DAYS	368,840	7	3,051	71,225	589	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 450,190	\$	\$ 86,931	25

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

# 0040931 Report Period Beginning: 01/01/2007

Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization CARLYLE NURSING ASSOC., LLC  
 Street Address 8140 RIVER DRIVE  
 City / State / Zip Code MORTON GROVE, IL 60053  
 Phone Number ( 847) 583-0100  
 Fax Number ( 847) 583-8873

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT HOURS	1	\$ 48,973	\$ 48,973	1	\$ 48,973	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	553,355	8,078		71,225	1,040	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	553,355	1,197		71,225	154	3
4	21	CLERICAL	PATIENT DAYS	553,355	13,541		71,225	1,743	4
5	24	TRAV EL	PATIENT DAYS	553,355	32,426		71,225	4,173	5
6	26	INSURANCE	PATIENT DAYS	553,355	21,389		71,225	2,753	6
7	30	DEPRECIATION	PATIENT DAYS	553,355	2,056		71,225	265	7
8	34	RENT	PATIENT DAYS	553,355	16,500		71,225	2,124	8
9	35	RENT - EQPT & VEHICLES	PATIENT DAYS	553,355	33,327		71,225	4,289	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 177,487	\$ 48,973		\$ 65,514	25

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

# 0040931 Report Period Beginning: 01/01/2007 Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization THE KENSINGTON GROUP, LLC  
 Street Address 8140 RIVER DRIVE  
 City / State / Zip Code MORTON GROVE, IL 60053  
 Phone Number ( 847) 583-0100  
 Fax Number ( 847) 583-8873

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	553,355	11	\$ 42,255	\$ 71,225	\$ 5,439	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	553,355	11	4,892	71,225	630	2
3	21	CLERICAL	PATIENT DAYS	553,355	11	203,886	71,225	26,242	3
4	24	TRAVEL	PATIENT DAYS	553,355	11	36,083	71,225	4,644	4
5	26	INSURANCE	PATIENT DAYS	553,355	11	28,435	71,225	3,660	5
6	30	DEPRECIATION	PATIENT DAYS	553,355	11	40,500	71,225	5,213	6
7	34	RENT	PATIENT DAYS	553,355	11	400,473	71,225	51,545	7
8	35	RENT - EQPT & VEHICLES	PATIENT DAYS	553,355	11	24,297	71,225	3,127	8
9							1		9
10	21	CLERICAL	DIRECT HOURS	1	1	184,635	184,635	184,635	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 965,456	\$ 184,635	\$ 285,135	25

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

# 0040931

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense
		YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>											
<b>Long-Term</b>											
1	RELATED PARTY - COUNTRYSIDE HEALTH CARE CENTRE						\$	\$			\$
2	CAPMARK		X	MORTGAGE	\$60,450.43	12/03	4,826,200	4,623,407	12/38	0.0540	251,181
3	CAPMARK		X	LOAN COST	35 YR AMORT	12/03	52,135	39,702			1,283
4											
5											
<b>Working Capital</b>											
6	LOAN PARTNERS	X		WORKING CAPITAL	VARIES	06/99	108,600		DEMAND	VARIES	17,343
7	RELATED PARTIES	X		WORKING CAPITAL	VARIES	12/98	498,989	380,045	DEMAND	VARIES	241,515
8	LETTER OF CREDIT FEES		X								1,379
9	TOTAL Facility Related				\$60,450.43		\$ 5,485,924	\$ 5,043,154			\$ 512,701
<b>B. Non-Facility Related*</b>											
10	IRS, IDR, ETC		X	LATE FEES							
11											
12											
13											
14	TOTAL Non-Facility Related						\$	\$			\$
15	TOTALS (line 9+line14)						\$ 5,485,924	\$ 5,043,154			\$ 512,701

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.     \$ N/A                      Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)**

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2006 report.		\$	<b>140,616</b>	<b>1</b>
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>146,807</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>6,191</b>	<b>3</b>
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>148,500</b>	<b>4</b>
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>154,691</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	<b>105,650</b>	<b>8</b>
	2003	<b>123,696</b>	<b>9</b>
	2004	<b>130,117</b>	<b>10</b>
	2005	<b>139,081</b>	<b>11</b>
	2006	<b>146,807</b>	<b>12</b>

<b>FOR BHF USE ONLY</b>			
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2006	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL**

**THE PAYMENT ON LINE 2 APPLIES TO THE 2006 TAX BILL.**

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2006 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME COUNTRYSIDE CARE CENTRE COUNTY KANE

FACILITY IDPH LICENSE NUMBER 0040931

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE ( 847 ) 675-3585 FAX #: ( 847 ) 675-5777

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2006 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>15-19-176-009</u>	<u>NURSING HOME</u>	\$ <u>146,806.66</u>	\$ <u>146,806.66</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>146,806.66</u>	\$ <u>146,806.66</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES       X       NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

# 0040931

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 59,536 B. General Construction Type: Exterior BRICK Frame STEEL CONST. Number of Stories 2

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)  
List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>NURSING HOME</u>	<u>130,679</u>	<u>1981</u>	<u>\$ 98,000</u>	<u>1</u>
2	<u>754 BASIS ADJ.</u>		<u>1982</u>	<u>16,345</u>	<u>2</u>
3	<b>TOTALS</b>	<b>130,679</b>		<b>\$ 114,345</b>	<b>3</b>

Facility Name &amp; ID Number COUNTRYSIDE CARE CENTRE

# 0040931

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	207	1981		\$ 2,111,156	\$	30	\$ 70,372	\$ 70,372	\$ 1,851,638	4
5	754 BASIS ADJ		1992	403,542	12,811	31.5	12,811		198,571	5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	*****RELATED PARTY - COUNTYSIDE HEALTHCARE CENTRE*****									
10	BUILDING IMPROVEMENTS		1982	40,076		15			40,076	10
11	VARIOUS IMPROVEMENTS		1983	26,282		15				11
12	VINYL TILING		1984	76,250		20			76,250	12
13	ROOF REPAIR		1985	6,644		20			6,644	13
14	VARIOUS IMPROVEMENTS		1986	1,609		15			1,609	14
15	VARIOUS IMPROVEMENTS		1987	36,433	1,156	31.5	1,156		36,020	15
16	BLACK TOP PAVING		1988	1,594		15			1,594	16
17	HOT WATER PIPING		1988	5,837	185	31.5	185		3,554	17
18	ROOFING IMPROVEMENTS		1989	51,879	1,647	31.5	1,647		30,813	18
19	SHOWER STALLS		1990	7,000	222	31.5	222		3,885	19
20	PAVING		1990	7,930		15			7,930	20
21	VARIOUS IMPROVEMENTS		1991	24,486	777	31.5	777		18,863	21
22	VARIOUS IMPROVEMENTS		1992	43,773	1,390	31.5	1,390		21,409	22
23	VARIOUS IMPROVEMENTS		1993	13,286	421	31.5	421		6,254	23
24	VARIOUS IMPROVEMENTS		1993	40,598	1,041	39	1,041		14,876	24
25	VARIOUS IMPROVEMENTS		1994	214,320	5,495	39	5,495		72,387	25
26	VARIOUS IMPROVEMENTS		1994	62,476	4,165	15	4,165		56,249	26
27	KITCHEN REMODEL/SIGNS		1995	32,836	842	39	842		10,878	27
28	ELECTRICAL & LIGHTING		1995	31,634	811	39	811		9,221	28
29	ROOFING/DOORS/DUCTWORK		1995	15,211	390	39	390		4,450	29
30	ROOF REPAIRS/FIRE DAMPERS		1996	4,300	110	39	110		1,307	30
31	BLACK TOP PAVING		1996	3,400	87	39	87		968	31
32	DUCTWORK		1996	8,584	220	39	220		2,429	32
33	REMOVE & REPLACE HVAC ROOF UNITS		1998	28,363	727	39	727		6,755	33
34	ROOF REPAIRS - PATCHING		1998	6,500	167	39	167		1,649	34
35	STAINLESS DUCTWORK - KITCHEN EXHAUST		1998	3,987	102	39	102		1,016	35
36	BOILER		1998	6,556	168	39	168		1,617	36

\*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name &amp; ID Number COUNTRYSIDE CARE CENTRE

# 0040931

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	WALLCOVERING, CARPETING, ARCHITECT WORK	1999	\$ 58,243	\$ 2,118	27.5	\$ 2,118	\$	\$ 18,974	37
38	WALLCOVERING, ALARMS/ELECTRIC WORKS	1999	27,515	1,001	27.5	1,001		8,877	38
39	REMODEL KITCHEN/WALLCOVERINGS/DRYWALL	1999	11,104	404	27.5	404		3,552	39
40	DINING RMS/WASHROOM-REMODEL/NEW ROOF	1999	165,984	6,036	27.5	6,036		52,557	40
41	LANDSCAPING/SECURITY PROJECT	1999	38,968	1,417	27.5	1,417		12,222	41
42	CONCRETE PATIO/DRAINAGE/DUCTWORK	1999	26,186	952	27.5	952		8,132	42
43	FLOOR TILES/WALLCOVERING/WALL REPAIRS	1999	127,185	4,625	27.5	4,625		39,113	43
44	IRRIGATION SYSTEMS/BTY STATIONS	1999	26,058	948	27.5	948		7,932	44
45	NEW ADDITION/EXHAUST FANS/INTERIOR WORK	1999	843,269	30,664	27.5	30,664		251,683	45
46	REMODEL - OFFICES/BATHROOMS/DINING	2000	72,465	2,635	27.5	2,635		20,970	46
47	FIRE DAMPERS AND FLOOR GRILLES	2000	5,226	190	27.5	190		1,512	47
48	DOORS/LAUNDRY RM/CORRIDOR-REMODEL	2000	64,257	2,337	27.5	2,337		17,814	48
49	ELEVATOR OPERATION PANEL	2000	4,490	163	27.5	163		1,243	49
50	LINT COLLECTOR/REMODELING PLANS	2000	7,595	276	27.5	276		2,059	50
51	SPRINKLER SYSTEMS	2000	8,550	311	27.5	311		2,320	51
52	ELEVATOR WANDERGUARD SYSTEM	2000	5,282	192	27.5	192		1,416	52
53	KITCHEN REMODELING/CARPETING	2000	82,957	3,017	27.5	3,017		22,245	53
54	HOT WATER REC. - MIXING VALVE & CIRCUIT SETTERS	2000	8,604	313	27.5	313		2,282	54
55	FRESH AIR INTAKES/ROOF STANDS	2000	23,244	845	27.5	845		6,162	55
56	FIRE ALARM/DOORS	2000	6,184	225	27.5	225		1,641	56
57	PARKING LOT EXPANSION	2000	35,624	1,295	27.5	1,295		9,443	57
58	GENERATORS	2000	92,626	3,368	27.5	3,368		24,278	58
59	LANDSCAPING/SECURITY PROJECT	2000	12,625	842	15	842		6,314	59
60	RESIDENT ROOM REMODELING & FURNISHING	2000	67,311	2,448	27.5	2,448		17,640	60
61	PATIENT WANDERING SYSTEM	2000	14,541	529	27.5	529		3,813	61
62	STIR FREE LINT FILTER	2000	1,399	51	27.5	51		368	62
63	NEW ROOF	2000	20,995	763	27.5	763		5,437	63
64	RESIDENT ROOM REMODELING & FURNISHING	2000	103,610	3,768	27.5	3,768		26,841	64
65	ROOF REPAIRS	2000	3,300	120	27.5	120		855	65
66	ROOF REPAIR & METACAULK FIRE STRIP	2000	11,211	408	27.5	408		2,873	66
67	ROOF TOP HVAC UNIT	2000	7,350	267	27.5	267		1,880	67
68	ELECTRICAL WORK/RESIDENT RMS REMODEL	2000	109,053	3,966	27.5	3,966		27,922	68
69	REMOVE/INSTL FLOOR & DRYWALL KITCHEN & LNDRY	2001	16,675	606	27.5	606		4,167	69
70	TOTAL (lines 4 thru 69)		\$ 5,426,228	\$ 110,034		\$ 180,406	\$ 70,372	\$ 3,129,731	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name &amp; ID Number COUNTRYSIDE CARE CENTRE

# 0040931

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 5,426,228	\$ 110,034		\$ 180,406	\$ 70,372	\$ 3,129,731	1
2	METAL SUPPORTS ON AIR RETURNS TO ROOF	2001	3,300	120	27.5	120		825	2
3	INSTALL HYDRAULIC PUMPING UNIT - KITCHEN ELEVATOR	2001	7,495	273	27.5	273		1,854	3
4	REPLACE WATER CLOSET 7 FLUSH VALVES - KITCHEN	2001	7,737	281	27.5	281		1,862	4
5	NEW HALL DOOR LOCKING ASSEMBLIES - ALL FLOORS	2001	2,885	105	27.5	105		687	5
6	PUMP FOR IRRIGATION SYSTEM	2001	1,825	66	27.5	66		432	6
7	INSTALL 4" FLOOR CLEANOUT ON SANITARY WASTE LINE	2001	6,783	247	27.5	247		1,492	7
8	INSTALLED 4 ELECTRIC HEATERS - CUSTOM	2002	5,297	193	27.5	193		1,150	8
9	ELECTRICAL WIRING FOR DISHWASHER & BOOSTER HEATER	2002	14,988	545	27.5	545		3,247	9
10	SHOWER ROOM REPAIRS, REMOVE OLD & FURNISH/INSTALL NEW	2002	26,388	960	27.5	960		5,716	10
11	REPLACED GEAR BOX ON INNER SLIDING ELEC. DOOR	2002	2,289	83	27.5	83		439	11
12	REMOVED & INSTALLED 2 HEAT EXCHANGERS	2002	2,040	74	27.5	74		385	12
13	REMOVE & INSTALL ROOF TOP HEAT EXCHANGER	2002	1,523	55	27.5	55		277	13
14	PARKING LOT - REMOVE & REPLACE ASPHALT	2002	87,477	5,832	15	5,832		32,297	14
15	F&I ONE INFRARED DOOR SCREEN ON SERV. ELEVATOR	2003	1,350	49	27.5	49		227	15
16	INSTALL 3/4" HP SUMP PUMP & 1-1/2 CK VALVE	2003	1,320	48	27.5	48		218	16
17	INSTALL WATER SOFTENER	2003	2,400	87	27.5	87		388	17
18	2-452E SINGLE SOFTENER; 450,000 GRAINS	2003	9,598	349	27.5	349		1,556	18
19	SUPPLY & INSTALL WIRING FOR NEW 208 VOLT FREEZER	2003	1,651	60	27.5	60		258	19
20	REMOVE & INSTALL AZT FLOOR, RMS 602, 611, 614, 705, 70	2003	3,666	133	27.5	133		538	20
21	INSTALLATION OF 75 LINEAR FOOT EXTENSION DRAIN	2004	25,374	923	27.5	923		3,269	21
22	REPAIRS TO SPRINKLER DUE TO NEW CONSTRUCTION	2004	2,264	82	27.5	82		277	22
23	OUTSIDE INJECTOR POWER PUMP	2004	3,646	133	27.5	133		449	23
24	PLANTING OF ALPINE TREES AS PART OF DRAINAGE PRG.	2004	3,751	250	15	250		875	24
25	NEW STORAGE GARAGE BUILDING	2004	81,144	2,951	27.5	2,951		9,712	25
26	COMPRESSOR	2004	2,100	76	27.5	76		250	26
27	NEW FIRE DOORS	2004	1,377	50	27.5	50		165	27
28	NEW AZT FLOOR TILES FOR RMS 806,812,303,512,313,314	2004	5,590	203	27.5	203		651	28
29	IRON RAILS FOR STAIR WELLS	2004	4,200	153	27.5	153		491	29
30	REPLACE FLOOR TILES & WALL TILES IN RMS 502, 505								30
31	506,511,512,514,805, & 807	2005	5,600	204	27.5	204		535	31
32	REMOVE OLD DUCT, FABRICATE & INSTALL NEW MAIN								32
33	TRUCK LINE, INSTALL NEW DIFFUSERS - 1ST FLR W. WIN	2005	28,000	1,018	27.5	1,018		2,672	33
34	TOTAL (lines 1 thru 33)		\$ 5,779,286	\$ 125,637		\$ 196,009	\$ 70,372	\$ 3,202,925	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name &amp; ID Number COUNTRYSIDE CARE CENTRE

# 0040931

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 5,779,286	\$ 125,637		\$ 196,009	\$ 70,372	\$ 3,202,925	1
2	REPLACE 5 TON CONDENSING UNIT FOR KITCHEN	2005	4,441	161	27.5	161		423	2
3	WALLPAPER IN 1ST FLR REST ROOMS/SHOWER RMS	2005	45,550	1,656	27.5	1,656		4,209	3
4	COMPLETE NEW ROOF ON 3 SECTIONS	2005	105,515	3,837	27.5	3,837		9,753	4
5	REMOVE & REPLACE A.O. SMITH WATER HEATER	2005	12,468	453	27.5	453		1,152	5
6	REPLACE SIDE WALKS	2005	4,000	145	27.5	145		357	6
7	INSTALLED FRAMES & ROOFED IN FRESH AIR TAKES	2005	5,530	201	27.5	201		461	7
8	INSTALL 2 TON MITSUBISHI UNIT FOR KITCHEN	2005	10,828	394	27.5	394		903	8
9	INSTALL DINING ROOM DOORS & FRAMES	2005	2,231	81	27.5	81		179	9
10	REMOVE & INSTALL VINYL FLOORING	2005	3,900	142	27.5	142		302	10
11	INSTALL 667 SQ YARDS OF NYLON CARPET	2005	38,420	1,397	27.5	1,397		2,969	11
12	A/C SPLIT SYSTEM FOR STORAGE RM, PAINTING & DRY-								12
13	WALL WORK, FIRE ALARM, SMOKE DETECTORS								13
14	ELECTICAL WORK IN OXYGEN STORAGE RM.	2005	16,511	600	27.5	600		1,275	14
15	REPLACE ROOF TOP UNIT - 1ST FLOOR DINING RM.	2005	9,842	358	27.5	358		761	15
16	F&I ELEVATOR SYSTEM CONTROLLER & TAPE	2006	14,875	541	27.5	541		1,059	16
17	ELECTRICAL PANEL & VENTILATORS OUTLET	2006	15,755	573	27.5	573		1,122	17
18	110 YARDS OF INTERFACE CARPET TILES IN ACTIVITY	2006	5,612	1,796	5	1,122	(674)	2,244	18
19	INSTALL HOT WATER LINE - KITCHEN TO LAUNDRY RM	2006	1,560	56	27.5	56		106	19
20	REPLACE BAD IGNITION MODULE, FLAME SENSORS								20
21	IGNITOR, GAS REGULATOR	2006	3,290	119	27.5	119		214	21
22	6 WOOD DOORS & 18 HINGE HARDWARE	2006	2,951	107	27.5	107		192	22
23	WALLCOVERING FOR 600, 700, 800 LOUNGES	2006	3,165	1,013	5	633	(380)	1,266	23
24	INSTALL ELECTRICAL WIRING FOR OFFICE A/C	2006	1,535	56	27.5	56		86	24
25	REPLACED WATER HEATER	2006	14,013	510	27.5	510		701	25
26	6 WOOD DOORS & 18 HINGE HARDWARE	2006	3,368	122	27.5	122		158	26
27	COUNTER TOPS FOR THERAPY ROOM	2007	714	24	27.5	24		24	27
28	INSTALL ELECTRICAL SUB PANELS IN CLOSET FOR CIRC	2007	8,555	285	27.5	285		285	28
29	WALLPAPER, TILES-1 & 2 FLR HALLWAYS & SHOWER RM	2007	115,000	3,485	27.5	3,485		3,485	29
30	FIRE DOOR	2007	1,932	59	27.5	59		59	30
31	INSTALLED VENDING MACHINE OUTLETS	2007	1,262	38	27.5	38		38	31
32	INSTALL MAIN EXHAUST FAN; REMODEL OF 8 SHOWER I	2007	22,000	600	27.5	600		600	32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,254,109	\$ 144,446		\$ 213,764	\$ 69,318	\$ 3,237,308	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name &amp; ID Number COUNTRYSIDE CARE CENTRE

# 0040931

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 6,254,109	\$ 144,446		\$ 213,764	\$ 69,318	\$ 3,237,308	1
2	CERAMIC TILE FOR BATHROOMS	2007	3,378	82	27.5	82		82	2
3	BONDING MORTAR, SAND MIX;OUTLET COVERS - 1 & 2 FL	2007	4,952	120	27.5	120		120	3
4	PIPE SHOWER VALVE; ATTACH GRID ON FLR DRAIN	2007	5,164	110	27.5	110		110	4
5	COMPLETE ROOF WORK	2007	81,900	1,737	27.5	1,737		1,737	5
6	TILES FOR FLOOR & WALLS - SHOWER ROOMS	2007	9,883	180	27.5	180		180	6
7	PATCH/REPAIR VISIBLE CRACKS-ROOF AND 600-900 WINC	2007	2,300	35	27.5	35		35	7
8	REPAIR HOT WATER LINE & REPLACE BATH RM VALVES	2007	1,751	21	27.5	21		21	8
9	MATERIALS FOR BATHROOM REMODEL	2007	9,451	86	27.5	86		86	9
10	PIPED IN 4 NEW SHOWER VALVES ALONG WITH BREAKE	2007	2,223	7	27.5	7		7	10
11	INSTALL 208 VOLT OUTLET IN KITCHEN	2007	882	3	27.5	3		3	11
12	INSTALL 2 SHOWER VALVES & REPIPED DRAIN	2007	1,195	4	27.5	4		4	12
13	REPLACE SOUTHWEST EXIT DOOR	2007	1,674	5	27.5	5		5	13
14	WALL COVERING, BORDERS, BLINDS, VALANCES FOR								14
15	1ST & 2ND FLR DINING RMS, RESIDENT ROOMS	2007	99,417	301	27.5	301		301	15
16	MATERIALS LIKE GROUT, TILE GLOSS BISC, FLANGE								16
17	FOR BATHROOM REMODEL	2007	2,224		27.5				17
18									18
19									19
20			ADJ TO SL	69,318			(69,318)		20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,480,503	\$ 216,455		\$ 216,455	\$	\$ 3,239,999	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **COUNTRYSIDE CARE CENTRE**

# **0040931**

Report Period Beginning:

**01/01/2007**

Ending:

**12/31/2007**

**XI. OWNERSHIP COSTS (continued)**

**C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,139,370	\$ 84,153	\$ 99,135	\$ 14,982	3-15 YRS	\$ 516,076	71
72	Current Year Purchases	180,093	29,281	9,005	(20,276)	3-15YRS		72
73	Fully Depreciated Assets	94,709					72,985	73
74	RELATED PARTY	6,847	6,523	6,523			6,156	74
75	TOTALS	\$ 1,421,019	\$ 119,957	\$ 114,663	\$ (5,294)		\$ 595,217	75

**D. Vehicle Depreciation (See instructions.)\***

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

**E. Summary of Care-Related Assets**

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,015,867	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 336,412	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 331,118	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (5,294)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,835,216	85

**F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)**

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

**G. Construction-in-Progress**

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 33,448 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_  
Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>/2008</u>	\$ _____
13.	<u>/2009</u>	\$ _____
14.	<u>/2010</u>	\$ _____

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input checked="" type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>HOURS PER CNA <u>20</u></p>
<p><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></p>		

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 420	\$	\$ 420
2	Books and Supplies		99		99
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$ 519	\$	\$ 519
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$	519		

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>1</b>

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 537,715	\$		\$ 537,715	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			111,659			111,659	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			658,810			658,810	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				266,734		266,734	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	LAB, X-RAY, RENTALS, I.V. TPY & Other (specify): <b>MEDICAL SUPPLIES</b>	39-2					169,215		169,215	13
14	<b>TOTAL</b>			\$		\$ 1,308,184	\$ 435,949		\$ 1,744,133	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name &amp; ID Number COUNTRYSIDE CARE CENTRE

# 0040931

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (113,243)	\$ (33,641)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>55,578</u> )	3,444,254	3,444,254	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments	1,883	1,883	5
6	Prepaid Insurance	68,780	128,546	6
7	Other Prepaid Expenses	31,764	31,764	7
8	Accounts Receivable (owners or related parties)	880	3,085	8
9	Other(specify): <u>ESCROW DEPOSITS</u>		315,641	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,434,318	\$ 3,891,532	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		98,000	13
14	Buildings, at Historical Cost		2,111,156	14
15	Leasehold Improvements, at Historical Cost		3,965,803	15
16	Equipment, at Historical Cost	1,414,171	1,414,171	16
17	Accumulated Depreciation (book methods)	(1,159,790)	(4,247,633)	17
18	Deferred Charges		39,702	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): _____			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 254,381	\$ 3,381,199	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,688,699	\$ 7,272,731	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,937,946	\$ 1,958,669	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	467,737	467,737	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	229,496	229,496	30
31	Accrued Taxes Payable (excluding real estate taxes)	32,695	32,695	31
32	Accrued Real Estate Taxes(Sch.IX-B)		148,500	32
33	Accrued Interest Payable		20,805	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>MANAGEMENT FEES</u>	557,671	557,671	36
37	<u>DUE TO LESSOR/PRIOR OWNER</u>	1,615,518		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 4,841,063	\$ 3,415,573	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	3,381,752	3,841,797	39
40	Mortgage Payable		4,623,407	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	_____			43
44	_____			44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 3,381,752	\$ 8,465,204	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 8,222,815	\$ 11,880,777	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (4,534,116)	\$ (4,608,046)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,688,699	\$ 7,272,731	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b>	
		<b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(3,717,843)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>ROUNDING ADJ.</b>	<b>6</b>	<b>3</b>
<b>4</b>	<b>REPLACEMENT TAX</b>	<b>437</b>	<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(3,717,400)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(816,716)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(816,716)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(4,534,116)</b>	<b>24</b> *

\* This must agree with page 17, line 47.

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 12,786,485	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 12,786,485	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	290	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 290	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	14,536	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 14,536	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 12,801,311	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,589,753	31
32	Health Care	5,290,298	32
33	General Administration	3,579,854	33
	<b>B. Capital Expense</b>		
34	Ownership	1,300,656	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	1,744,133	35
36	Provider Participation Fee	113,333	36
	<b>D. Other Expenses (specify):</b>		
37	<b>OUT-OF-PERIOD EXPENSES</b>		37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 13,618,027	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(816,716)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (816,716)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

TAX RETURN PREPARED ON CASH BASIS

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number COUNTRYSIDE CARE CENTRE

# 0040931

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,861	2,086	\$ 76,912	\$ 36.87	1
2	Assistant Director of Nursing	3,673	4,160	125,516	30.17	2
3	Registered Nurses	42,379	46,438	1,277,839	27.52	3
4	Licensed Practical Nurses	35,394	38,664	1,016,645	26.29	4
5	CNAs & Orderlies	120,508	128,395	1,776,332	13.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,653	3,918	56,331	14.38	8
9	Activity Director	3,651	4,306	62,427	14.50	9
10	Activity Assistants	6,431	6,806	64,094	9.42	10
11	Social Service Workers	5,205	5,649	96,569	17.09	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	9,408	10,751	156,942	14.60	14
15	Cook Helpers/Assistants	21,820	23,080	195,772	8.48	15
16	Dishwashers					16
17	Maintenance Workers	2,001	2,171	48,765	22.46	17
18	Housekeepers	28,869	30,862	293,577	9.51	18
19	Laundry	3,616	4,031	43,021	10.67	19
20	Administrator	1,960	2,181	160,489	73.59	20
21	Assistant Administrator	1,816	2,311	52,071	22.53	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,644	10,873	199,536	18.35	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	8,898	9,814	209,880	21.39	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	310,787	336,496	\$ 5,912,718 *	\$ 17.57	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	313	\$ 19,588	1-3	35
36	Medical Director	132	15,000	9-3	36
37	Medical Records Consultant	32	1,504	10-3	37
38	Nurse Consultant	564	119,653	10-3	38
39	Pharmacist Consultant	96	2,400	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant	15	735	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	18	1,065	11-3	44
45	Social Service Consultant	116	10,202	12-3	45
46	Other(specify) <u>UTILIZATION REV</u>	36	6,000	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,322	\$ 176,147		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53



**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2004	FY2005	FY2006	FY2007
1	<b>PAINT/DECORATING</b>	<b>2005</b>	<b>\$ 4,033</b>	<b>3</b>	\$	<b>\$ 672</b>	<b>\$ 1,344</b>	<b>\$ 1,344</b>	<b>\$ 673</b>	\$	\$	\$								
2	<b>PAINT/DECORATING</b>	<b>2006</b>	<b>1,961</b>	<b>3</b>			<b>326</b>	<b>654</b>	<b>654</b>	<b>327</b>										
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20	<b>TOTALS</b>		<b>\$ 5,994</b>		\$	<b>\$ 672</b>	<b>\$ 1,670</b>	<b>\$ 1,998</b>	<b>\$ 1,327</b>	<b>\$ 327</b>	\$	\$								

Facility Name &amp; ID Number COUNTRYSIDE CARE CENTRE

# 0040931

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. ILL COUNCIL ON LTC - \$10575.4
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,946 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 113,333  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
g. **Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees